Leicester Safeguarding Children Board

Multi-agency Learning and Improvement Summary following a Serious Case Review

Robyn

SUMMARY REPORT

Final Version – December 2018

Foreword

Response from the Chair, Leicester Safeguarding Children Board

This review was originally commission by the previous Independent Chair in February 2015. Serious case reviews are sometimes carried out when a child or young person dies or is seriously injured, neglect or abuse is suspected and there are concerns about the way agencies worked together to keep them safe. They are written by independent authors and look at the role played by any professionals involved with the child and their family, to see if lessons can be learned and ways of working can be improved.

This review relates to a baby who was taken to hospital with injuries when they were too young to have harmed themselves accidentally. The review tells a distressing story of children harmed by parents who should have been protecting them, and this has saddened us all.

All the agencies involved in these reviews accept the findings of this review. Since these cases there has been a major overhaul of the LSCB's policies and procedures, reflecting the need for all partners to work more closely together to identify early on when children are at risk. The learning from both this review and a similar Serious Case Review (Nadiya 2018) carried out at the same time have identified several actions which have now been implemented by the partner agencies involved.

The guidance on non-accidental injuries in babies, pre-birth assessments and neglect has all been updated, while robust procedures have been put in place to check on the progress of child protection plans. The LSCB has also hosted learning events for other agencies.

There were also parallel processes taking place which prevented the publication of any report until they were concluded. This learning and improvement summary is now published setting out the findings and outcomes of the review and to provide assurance of the learning and improvement undertaken and its impact on current child safeguarding practice.

Jenny Myers
Independent Chair
Leicester Safeguarding Children Board

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1. Introduction

1.1. This report summarises the findings of an independently-led Serious Case Review which was commissioned by the previous Chair of Leicester Safeguarding Children Board (LSCB) in January 2015.

1.2. The purpose of the review, which was conducted in line with the requirements of statutory guidance at the time, was to:

- understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight;
- be transparent about the way data was collected and analysed; and
- make use of relevant research and case evidence to inform the findings.

Working Together HM Government (2015:74)

Background

1.3. This Serious Case Review is in respect of Robyn who in September 2014 was presented at the emergency department of the University Hospitals of Leicester NHS Trust (UHL) by her parents, with a swollen right leg. Medical investigations identified that Robyn had a spiral fracture which was deemed a non-accidental injury. Subsequent investigations discovered that there were fractures of the right femur, ribs and lower left leg. These fractures were said to have occurred on at least three separate occasions and required at least five separate applications of force.

1.4. Robyn came to the attention of agencies on several occasions prior to the injuries being seen. This was primarily due to poor home conditions, neglectful care and concerns regarding the mental health of the father and mother. Prior to the above incident, there was bruising seen on Robyn the previous month by the out of hours GP, Robyn was presented at University Hospitals of Leicester NHS Trust, three days later with blood in vomit and Robyn was observed with multiple bruising by the Health Visitor (HV) the following week. Despite Robyn being a non-independently mobile baby Child Protection procedures were not followed.

2. Scope of the review

2.1. The Serious Case Review scope covered information regarding professional involvement with the family from November 2013 to the point of when the injuries to Robyn were discovered in September 2015.

2.2. It was agreed to undertake this overview report which was to contribute to the overarching Overview Report using a traditional Serious Case Review model with specific terms of reference as follows:

- Appraise the quality of work in this case

- Establish what lessons can be learned about the quality and effectiveness of agency and multiagency working
- Identify the key themes that characterised work with this family
- Put individual performance in a systemic context
- Make proposals for improvement where any shortfalls are identified
- Involve front line staff and family members in the review

2.3. It was expected that the process of the review would generate new knowledge about the local safeguarding system and reviewers would identify key themes. It was agreed that the reviews would have a key underlying question:

- *Could the child have been protected earlier? If so, why, and what would enable this to happen with future children in a similar position?*

2.4. The review was conducted using the national guidance in place at the time Working Together to Safeguard Children 2015. Because the three reviews were grouped by key topic there was a particular focus on:

- The adequacy of and adherence to policies and procedures around injuries to babies;
- The adequacy of and adherence to policies and procedures around pre-birth assessments and planning;
- The effectiveness of the interface between children and adult services;
- The impact of equality and diversity factors on practice, particularly culture and disability.

2.5. The review process adopted the traditional approach of requesting individual management reviews (IMRs) from agencies. In addition, a practitioner event for those providing care to Robyn and her family was held to gain further insights and inform the learning. The practitioner event was also attended by several of the IMR report authors and a few of the front-line practitioners involved in the case, as many of the practitioners were no longer working for the organisation. Also, some telephone interviews were conducted with involved practitioners. Therefore, this meant that the contribution of those involved in providing services to the family at the time was limited.

2.6. The family were notified that a Serious Case Review would be taking place. It has not been possible to interview Robyn's parents as they have been unable to attend appointments, despite them initially agreeing to meet with the Independent Reviewer. They have been given the opportunity to advise the reviewer of anything they feel is pertinent either via a telephone call or in writing, but this offer was not taken up. The parents of Robyn were offered a further opportunity to be involved in the review following the conclusion of the criminal proceedings.

2.7. A Multi-agency Review Panel, chaired by the Lead Reviewer and Composite Overview Report Author, was established at the outset. The Panel, which met on three occasions comprised of senior leads from the following agencies and organisations:

- Leicester Clinical Commissioning Group
- Leicester City Council Adult Services
- Leicester City Council Children's Social Care
- Leicestershire Partnership NHS Trust

- Leicestershire Police
- University Hospitals of Leicester NHS Trust

2.8. The review process was supported by the Interim LSCB manager in post at the time, LSCB Policy Officer and an LSCB Admin and Business Support Officer.

2.9. The findings of the review have been reported to a full board meeting of the LSCB.

3. Brief family background and synopsis of the case

3.1. Robyn and both her parents are of White British heritage and identified with the local culture where they lived. At the time of the serious injury Robyn lived with both her parents at the home of their maternal great grandmother. Both parents had high needs and had grown up experiencing abuse and neglect. Both parents had mental health problems. Very few agencies recorded any information in respect of this. Robyn's mother was classed as Looked After Child and received leaving care services.

3.2. There is a long history of involvement with Robyn's mother dating back to her early childhood in relation to concerns of physical harm which resulted in her living with her maternal grandmother in 2005. Further concerns resulted in investigation by Leicestershire Police and Children's Social Care and for a time mother was in residential care as a 'Looked After Child'. The further concerns included allegations of physical harm and non-recent intrafamilial sexual abuse. Mother remained in the care of the local authority until her 18th birthday at which time she was described as 'sofa surfing'. However, she returned to live with her maternal grandmother in spring 2013 to provide care for due to her daily living needs.

3.3. Robyn's father and his siblings were also known to Children's Social Care throughout his early childhood due to concerns regarding experience of domestic abuse and physical harm. As such he became subject to a Child Protection Plan in December 2003 and a year later the children then became children in need (CiN). The combined family experiences of Robyn's parents were very dysfunctional, with considerable experience of being abused, and with no role models for good parenting. All this was known at the time the mother became pregnant in autumn 2013.

3.4. Robyn was born in the Summer of 2014 at 41 weeks at the local hospital. This was a normal birth and Robyn was observed to be in good health and feeding well and of a good birth weight. When only a day-old Robyn was left unattended on the ward after her mother informed staff she was going to the reception area and, following contact by staff, eventually came back to the ward after two and a half hours. This information was recorded in the mother's notes but was not shared with any other agencies. Robyn was discharged from hospital when she was two days old and four visits were undertaken by the community midwife which did not raise any concerns.

3.5. In the following eight weeks there were several key episodes where concern about parenting capacity or indicators of possible abuse or neglect were noted by professionals:

- At a new birth visit the living area of the flat was noted to be cluttered with baby equipment and the remains of a bed. Robyn was observed to be developing in line with expectations and had maintained weight. The mother's current and historical mental health was explored, and it was identified that the mother had been seen and prescribed medication by her GP the previous week for low mood but had stopped taking it. Advise was given to see her GP and a referral to the stop smoking service offered. Following this visit there was liaison with the allocated Health Visitor requesting a follow up visit to be undertaken.
- The follow up visit was undertaken the following week and Robyn was seen and progressing well, advice was given regarding feeding and management of wind. Two days later mother attended her local hospital with Robyn expressing concern as the baby had been crying inconsolably, vomiting and with stomach pains, she thought Robyn may have had trapped wind, advice was given, and Robyn discharged.
- Three days later Robyn was seen by an out of hours GP. Bruising was noted to her back and there was concern regarding this being a possible non-accidental injury. There was liaison between the out of hours GP and Robyn's GP who agreed to see the baby later that day, although Robyn was not seen at the GP Practice for a further two weeks.
- The following day Robyn was taken to accident and emergency with blood in her vomit. Robyn was admitted for blood tests and later discharged home with the parents. Robyn was fully observed and assessed, and safeguarding concerns were discounted. A heart murmur was noted during this appointment and a referral made to the cardiac department for an assessment.
- The next day, which was a Saturday, the mother called a member of the health visiting team on their home number and informed them that Robyn had attended the Urgent Care Centre the previous day as she had vomited blood. The mother stated that the doctor had bruised Robyn's arm when he took blood and asked her to review the bruise. It was agreed that a colleague would be asked on Monday to review the bruise and that Children's Social Care (CSC) would be informed.
- Despite being on annual leave and being called unexpectedly at her home, the HV liaised with their colleague and they arranged to see Robyn at the Sure Start Centre the same day, two days following the bruise being reported.
- Robyn was seen accompanied by her mother as planned by two Health Visitors to review the marks. The parents reported that two doctors had attempted to take blood from several sites and they had left bruising and red marks. Robyn was seen naked and the marks were recorded on a paper body map and placed in the Personal Child Health Record (red book).
- The hospital records for Robyn note only one bruise as being observed while the body map within the health visiting records indicated multiple marks were observed by the two Health Visitors.
- A referral was made to the Duty and Assessment Team (DAT), CSC informing them of Robyn's recent hospital attendance and the marks which parents had stated were left from attempted blood tests. The DAT Social Worker asked that the HV confirm that Robyn had attended hospital and that more information was required before they would accept the referral.
- The DAT Social Worker also contacted the safeguarding nurse at the hospital who confirmed that three attempts had been made to take blood from Robyn but that the doctor had only recorded one bruise to the back of Robyn's hand. This is a discrepancy as the Social Worker

recorded that Robyn had three bruises and the Health Visitor records identify eleven different marks on Robyn.

- The Social Worker after speaking to the hospital concludes that the marks are consistent with blood being taken. Robyn was not seen nor was a Child Protection medical undertaken.
- The DAT Social Worker then contacted the Personal Adviser and the mother. The parents advised the DAT social worker that they had noticed the bruise from the blood test after returning home and rang the hospital to tell them and the mother stated that the doctor agreed to put a note in Robyn's medical records regarding what had happened.
- Given that mother has clearly advised that no bruising was observed by the hospital and the number of bruises to a very young baby, a Strategy Discussion should have been held and progressed to a S47 investigation and Child Protection Medical.
- Three days later the Personal Adviser undertook a home visit and Robyn's parents were seen. The PA noticed a sign on the door to say no visitors after 4.00pm and explored what this was for and was told it applies to family because they want to eat at 5.00pm and bath Robyn at 6.00pm ready to settle for sleep and did not want to be disturbed. The PA noted that they appeared to be prioritising Robyn's needs.
- The father is noted to play a more participative role during this visit and stated that he was particularly upset with his mother because she comes into the house and 'gushes' all over the baby and he gets ignored. This issue was not explored further with the father to see how he was feeling towards Robyn.
- The mother disclosed that the father had told her something that made her feel unsafe to leave Robyn unattended with the paternal grandparents due to an incident the father experienced when he was eight and was physically assaulted by his father. This had made the father angry as they are being nice to Robyn when he had such a poor childhood. There was no exploration of how these angry feelings manifested and whether the father ever felt angry towards Robyn.
- The mother further disclosed that she has been to the doctor since the birth of Robyn regarding her depression and has been given some medication but had not taken this due to the side effects.
- The PA contacted the HV advising of the concerns raised during the visit to the family the previous day. The HV agreed to visit that day and to speak to the GP regarding an appointment to assess the father's mental health. The HV also contacted the Safeguarding Children's Advice line and spoke to the Named Nurse for Safeguarding Children. She was advised to request that the PA made a safeguarding referral to DAT. Following discussion with the PA this was actioned and was followed up by the HV later that day.
- Later that morning the HV conducted a home visit, the father continued to disclose that he had thoughts of wanting to harm the mother and that his worst thought was to throw her over the balcony. These thoughts happen from once a day to many times a day. He also disclosed a history of physical abuse from his parents, self-harm as well as an attempted suicide which failed due to the ligature breaking. He had caused a self-inflicted injury to himself following an argument with the mother of Robyn. He also disclosed that he had a previous history of cannabis misuse.
- The father did not disclose any current self-harming or suicidal thoughts. The mother informed the HV that she was scared about what she was hearing, and she spoke about

places of safety she could go to and calling the police if things got out of control. It is not recorded whether Robyn was seen at this visit.

- Following this visit the HV went to the GP surgery and expressed her safeguarding concerns to the GP who did not see the necessity in seeing the father until the following week and advised that he did not perceive the father to be a risk '*as he had not actioned his thoughts.'*
- This decision was challenged by the HV but did not get an immediate response from the GP for an earlier appointment. The HV continued to liaise with CSC during that day and the GP reconsidered his earlier stance and offered to see the father later that same evening. The GP undertook a consultation with father that evening and concluded that he did not have any concerns about the father being a risk to his family.
- Further recordings made by CSC miss the key responsibility CSC had in ensuring an appropriate Safeguarding Plan was in place for Robyn. CSC had a duty to safeguard children and an assessment would have identified what risks were present before reaching such a conclusion. However, the referral was closed with no further action.
- There was a series of attempted telephone calls and two failed home visits by the HV, the first the day of the GP consultation with father and the second five days later.
- The next day contact was made, and a home visit undertaken, Robyn had gained weight and remained on her birth centile. She was appropriately dressed, observed to smile, make noises and play with the hands. Emotional warmth was observed between the mother and Robyn.
- Both parents spoke of the situation at home having improved, the father had found it beneficial to talk about how he was feeling and was now sleeping much better and no longer had feelings of wanting to harm the mother. If he felt stressed whilst caring for Robyn, he stated that he would hand the baby back to the mother. The father indicated to the HV that he had a family history of bipolar disorder, but this was not explored further with him.
- Robyn was taken by the parents for a cardiac outpatient appointment in early September which was thought to be an incidental murmur and therefore they discharged the baby from their care.
- At this appointment it was recorded by a Health Care Assistant that she had "grave concerns" regarding Robyn which were escalated to the cardiac liaison nurse, who met with the family immediately. She had no concerns regarding Robyn and the care of the baby by the parents but did have concerns regarding mother being unsteady on her feet, reportedly due to taking Tramadol for pain. The mother was advised to make an appointment to see her GP.
- This is the second incident whereby mother has either been using or asked for prescription medication which is opiate based. During this episode there was no exploration as to why mother was taking the medication or who had given it to her.

3.6. The next day Robyn who was now 8 Weeks old had been presented at the Leicester Royal Infirmary Accident & Emergency Department with a fractured femur. Further tests indicated there were a range of fractures that were highly likely to be non-accidental and occurring at different times.

4. Discussion of key findings

4.1. This review raises several significant and worrying practice issues as follows:

- The Marginalisation of Fathers
- Ineffective Child Protection Processes
- Pre-birth Assessment Processes
- Identification and Assessment of Parental Risk Factors

4.2. Despite evidence to the contrary, professionals displayed optimism about the parent's ability to provide appropriate care for Robyn. The range of risk factors known regarding both parents were not investigated or interrogated in a meaningful way.

5. Conclusion

5.1. The decision making at the 'front door' in respect of this case is a cause for concern. On two occasions information was received which clearly evidenced Child Protection concerns. The first incident related to bruising on Robyn. The second incident involved father's mental health and thoughts of harming mother whilst she was holding Robyn. The response to both of these referrals was wholly inadequate and left Robyn at risk of serious harm.

5.2. This case has also identified that threshold decisions in the whole are not understood across the partnership. The case clearly had dimensions of risk and early indicators of harm or potential harm yet did not progress into the Child Protection arena. When there has been clear evidence of harm and risk when Robyn was observed with bruising this has not progressed to assessment within CSCs.

Could the child have been protected earlier?

5.3. This review clearly evidences that Robyn could have been protected at an earlier stage. In the pre-birth period there were enough indicators of risk to predict potential harm. The systemic failures across the partnership in respect of bruising to non-mobile babies and a disregard for the existing policy ensured that the later injuries that Robyn sustained were predictable and avoidable.

5.4. This was acerbated by the analysis of the father's very worrying thoughts being considered as low risk by the GP, and not worthy of an assessment by Children and Young Peoples Services, even when heard so soon after the bruising. Compounded further by CSC not even visiting the family in the three weeks between the mental health revelations and the thigh injury that led to hospitalisation.

5.5. There was the failure to properly refer and investigate the bruising in the month before injuries were diagnosed. The GPs failed to refer or seek expert medical advice on bruising to a non-mobile child. Had they done so Non-Accidental Injury (NAI) may have been diagnosed and the first rib fractures may have been seen.

5.6. It could also be argued that the injuries may have been prevented had the inherent risks from the parents troubled and violent upbringing been properly assessed at pre-birth and had there been any consideration of history when the current work was done with the parents. The parents could have had support from staff expert in Child Protection and with an approach which was more sceptical about their abilities.

6. Recommendations

6.1. As part of this Serious Case Review all agencies involved with the family at the time completed IMRs on behalf of their agency and have worked to an action plan reporting on its progress at successive internals so that the LSCB could be assured the single agency learning identified had been progressed and embedded in practice. At an Extraordinary meeting of the Serious Incident Review Group held in July 2018 each agency reported on the impact of their actions for a final time. All actions were reported as having been completed (or in some instances superseded by other reviews or structural changes) and the impact. The summary of multi-agency learning, response and assurance report was noted and acknowledged by the group. It was agreed this would form the basis of the report to Board with the learning distilled into the report for Board.

6.2. The following LSCB recommendations which were part of the original individual overview report for this case were also monitored and evaluated:

Recommendation1: LSCB to assure itself that decision making in the Duty and Assessment Service is safe and ensure that current assessment and referral procedures are effective in taking a holistic approach to both current and historic safeguarding issues.
The LSCB has received ongoing assurance regarding the arrangements in place at the front-door to ensure that the revised Duty and Advice Service is safe, and that current assessment and referral procedures are effective in taking a holistic approach to both current and historic safeguarding issues. Assurance evidence is also available within the recent Ofsted Inspection and the Local Authority Self-Assessment.

Recommendation 2: The LSCB to urgently satisfy itself that current arrangements and understanding regarding threshold decisions are safe and robustly adhered to.
The LLR Thresholds document, Access to Services has been refreshed and revalidated and several learning events have taken place. The threshold in relation to referrals has been addressed within performance meetings which involve partner agencies. The relaunch of threshold document has already seen a much better understanding of thresholds and consistent application from partners.

Recommendation 3: The LSCB to review and ensure compliance with Child Protection Procedures.
The LSCB has received ongoing assurance regarding compliance with Child Protection Procedures through its Performance, Analysis and Assurance Group (PAAG) which show that the right cases are coming through the front-door. Assurance evidence is also available within the recent Ofsted Inspection and the Local Authority Self-Assessment. The thresholds for progressing cases from CIN to

Child Protection are identified within the Local Authority Quality Assurance Framework and escalated by the Safeguarding Unit as and when required.

Recommendation 4: Multi-Agency Thematic audit to be undertaken regarding referrals which have been closed as NFA or signposted to Early Help Services by the Duty and Assessment Team to ensure compliance with agreed thresholds and to ensure compliance with Working Together 2015.
The LSCB has a robust system of audit and quality assurance for testing out the quality of referrals, decision making and their outcomes, this has demonstrated compliance with agreed thresholds and to ensure compliance with Working Together 2015.

Recommendation 5: The LSCB to assure itself that assessments which focus on unborn children or babies fully involve fathers and that risk and safeguarding concerns are fully considered.
The LSCB has a robust system of audit and quality assurance for testing out the quality of information and response to unborn babies and that assessment fully involve father. It has completed an audit on the response to pre-birth assessment in March 2017:
http://www.lcitylscb.org/media/1335/20170310-pre-birth-multiagency-audit-summary-v3.pdf*.*

Recommendation 6: LSCB to assure itself that there are clear pathways in place for dealing with unborn children living in complex family situations which encompass a range of difficulties including adult services and mental health. To ensure that timely pre-birth assessments take place and encompass a whole family approach.
Audits have identified that there are clear pathways in place for dealing with unborn children living in complex family situation pre-birth plans are more focused and outcomes are achieved in a timelier way. Senior managers within LCC CSC regularly review all unborn children on Children Protection Plans to ensure that plans are being progressed appropriately and that progress is being made to achieve their stated outcomes in a timely way.

Recommendation 7: Consideration to carrying out a Thematic Audit to ensure that pre-birth assessments are routinely being carried out whenever there may be safeguarding risks to the unborn child and that the timing of when those assessments commence is appropriate. The audit will identify there are adequate systems in place for quality assuring pre-birth assessments in their area.
As above the LSCB has completed an audit on the quality of pre-birth assessment in March 2017. There are plans in place to further test the quality of the response to unborn babies and infants in 2019-20. Through the multi-agency case audits there has been evidence of improved management oversight, practice and outcomes for children

Recommendation 8: The learning from this Serious Case Review should be disseminated amongst social care practitioners as soon as possible due to the serious and systemic failings noted.
The learning from this Serious Case Review has been disseminated at large scale learning from experience events as well as lunch and learn bite size learning events and within practitioner briefings. The learning has also been tested through surveys of frontline practitioners.

In conclusion, there has been much scrutiny and challenge over the last three years and recognition from Ofsted and other external partners that a lot of progress has been made in improving the multi-agency safeguarding system for children including the identification of neglect, physical abuse,

the quality of Child Protection Plans and escalation protocol. Consistency of approach and response going forwards is important and the implementation of the Signs of Safety model by the Local Authority and sign up to this by the LSCB partners is one of the ways the system is evolving and improving in Leicester City.

Glossary of Abbreviations

CiN - Child in Need
CPC - Child Protection Conference
CPP - Child Protection Plan
GP - General Practitioner
IMR - Individual Management Review
LSCB - Leicester Safeguarding Children Board